Note to RIW members:

This draft is a working document undergoing continual revision up to an including the RIW meeting in Rockville, MD. A revised version of Section 2 to replace this version will be available at the RIW meeting or you may check the RIW website regularly for interim revisions.

The document is intended to begin articulating issues and recommendations that the RIW may choose to include in its final report due in June. The text of this document is not polished and will undergo additional revisions.

SECTION 2

(version 1.0—4/24/02)

Consolidations with HHS – the short run

The Director, IHS asked us (the RIW) to identify changes to address health care needs of Indian people and to improve the Indian health system. He also asked us to consider how the Indian health system fits into the President's Management Agenda and initiatives of the Department of Health and Human Resources. In responding to this charge, we must frame our message wisely.

Our Message –

On one hand, part of our message is a long range vision for Indian health care, articulated recently by the National Indian Health Board, to double health care available to Indian people and to eliminate health status disparities between AIAN and other Americans. Achieving these national goals requires, in addition to improving efficiency of the existing system, a serious commitment to double resources available to the Indian health care system in a reasonable period of time. We believe any restructuring recommendations must be consistent with this part of our message.

On the other hand, the Indian health system, like the health care industry in general, is experiencing escalating price inflation and a expanding beneficiary population. Together,

these forces are creating unprecedented demands on the Indian health care system. Unfortunately, the budget to meet these expanding needs has been static in real buying power terms. Given this realty and the events of September 11, we understand why the Department is pushing for improved efficiencies, stream lining and cohesion among all DHHS agencies. We understand the realities of "belt-tightening" and that the Indian health system must continually adapt to be more productive and effective. We understand that some consolidation and flattening may be appropriate. These actions can be beneficial to the extent they make more services available to Indian people. However, we can not focus solely on "belt-tightening" because this approach can not close the gap in services or eliminate health status disparities. We can not detract from the message that Indian health care must be expanded if health disparities are to be eliminated.

We feel that our report needs to respond to the President's Management Agenda. In the end, even if it proposes to double the budget, we want to show how our plans are "citizen centered", "results oriented," and "market based".

Our Concerns –

We also have identified some concerns about consolidating functions among agencies within HHS.

- We are unable to reassure ourselves that consolidations will not detract from essential principles preserving sovereignty of tribal nations or will not diminish services to the already underserved Indian population.
- We support increased efficiencies that generate "savings", but given the severe under funding of Indian health care and lingering health status disparities afflicting Indian people, we strongly feel that all restructuring "savings" must be reinvested into additional health care services to AIAN.

- Other concerns about the wisdom of consolidation relate to the uniqueness of the Indian health system that is based in hundreds of remote Indian communities – very different in structure, function and location from most agencies in the DHHS.
- We are not certain that an aggregate of parts consolidated from dissimilar programs from several agencies can function effectively.
- We are concerned that resources consolidated from the IHS will become diluted, lose focus and jeopardize the specialized experience and support services relied on by our frontline community based health care system.
- Finally, we have not seen HHS plans for most consolidation proposals that were sufficiently detailed for us to adequately evaluate their merit or impact. In some cases we are unable to conclude the best course of action and are understandably reluctant to endorse some proposals because of this uncertainty.

Our Approach –

For these reasons, we can not endorse all of the HHS proposals we have evaluated. We feel obligated to clearly state in what way the proposals are inconsistent with one or more of our essential principles and goals. In other cases, we may endorse the reason or goal that the consolidation proposal is intended to address, but not the means proposed to achieve that goal. Where we have concerns about HHS proposals, we want to offer alternatives for consideration that we believe are generally consistent with the goals outlined by the President and Secretary although specific means to achieve those goals may differ. We feel there are ways to achieve many goals that we share with the President and Secretary through alternative means that are less disruptive to the Indian Health system.

Our Detailed Assessment –

Consolidation of Public Affairs and Legislative Affairs to DHHS

This proposal would transfer 8 FTE (and $) from IHS to DHHS. We have mixed views about this proposal and have identified both potential benefits and concerns:

Pros:

- No physical relocation
- Maintains immediate access to agency leadership
- Perceived as better connected to HHS
- Enhanced visibility of IHS issues

Cons:

- Potential dilution of IHS focus
- IHS legislative staff are under close HHS supervision for "on the record" activities already
- Tribal leaders generally strongly oppose transfer of the legislative function
- Longer clearance time may impede rapid response
- Transfer of resources (though minimal) has tribal shares implications
- Indian Preference is lost for these 5 positions
- Resources must be tracked for Tribal shares

These offices provide a critical liaison between the Congress, the IHS administration, the DHHS administration, tribal governments, and Indian communities. To be most effective they must be closely connected with the IHS administrative offices. The relationship of the Indian Health Service with the Congress is unique within the DHHS, with separate appropriations processes and oversight committees.

We discussed consolidation of the Public Affairs staff and saw some potential benefit, chiefly the elevation of the public information—communication support. Elevation/consolidation could be beneficial if the Department better and more routinely articulates AIAN health issues. On the other hand, if the staff is absorbed into the

Department's work and if they are slowed because more people have to sign off, the impacts could be negative. The issue of the IHS Legislative Affairs office has been discussed in a number of forums through out Indian Country. The overwhelming view among tribal leaders is that this function should not be moved out of the agency. In both instances, we understand a primary objective for undertaking these consolidations is to bring a more cohesive approach to legislation and public information among all the HHS agencies.

Recommendation: The HHS and IHS leadership should identify mutually agreeable solutions to assure coordination among offices in the event of national emergencies and on major cross-cutting issues. These solutions could take form as more detailed performance contracts or even "memorandum of agreement" that officially specify terms acceptable to the Secretary and the Director. In this way, the goals sought by HHS leadership could be achieved without negative implications of transferring offices or staff.

Consolidation of Public Affairs and Legislative Affairs to DHHS

We were unable to evaluate detailed plans for consolidating human resources within DHHS. We understand plans or still being formulated. The DHHS has set a goal to reduce to 4 human resources offices. A March 28, 2002 letter from Ed Sontag, ASAM seeks IHS nominations to participate on a HHS human resources consolidation team. This letter states "consolidation of most of these functions must be completed by the end of FY 2003." It is difficult to evaluate vague plans, but we have considered the situation in IHS and have identified a number of concerns.

Opportunities/Pros

- Recruitment and retention of high quality health care personnel through out the Indian health care system is critical, but especially in remote and isolated reservations.

- A thorough assessment of the IHS human resources support function is appropriate. It is difficult for us to formulate a detailed human resources restructuring plan, but we are willing to consider proposals designed to improve recruitment, retention, and provide other critical HR support functions in the more than 300 health care locations in the Indian health system. We believe performance and support can be improved through a number of measures.
- IHS management has explored very preliminary proposals to consolidate/restructure operational elements of the IHS human resources function which are now distributed in numerous locations throughout the IHS system. Consolidation of selected functions has potential to offer better support, higher levels of expertise, and more depth than is currently available. We have not yet evaluated these ideas and will need additional time to adequately assess and evaluate the benefits.
- With respect to the "market-based" goal, it is worthwhile to consider whether outside sources might provide certain HR support functions. As with all IHS functions, tribal nations have first opportunity to contract for services formerly carried out by the agencies. Additionally, there may be Indian owned firms able to carry out selected functions under various types of contracts.
- We also see opportunities to further automate record keeping and retrieval, pay roll, etc. with newer technologies and software.

Concerns/Cons

We have some concerns about consolidation of IHS human resources functions within DHHS. Our concerns arise chiefly from doubts that multi-agency HR offices will actually produce the needed results in the field especially considering the uniqueness of the IHS medical care system of over 300 sites, many in remote rural locations—very different in the structure from all the rest of the HHS agencies.

- The IHS workforce is composed of frontline health care providers and support staff and is fundamentally different in character than the workforce in most HHS agencies.
- IHS operates under unique law applying Indian Preference in hiring and promotion practices—76% of the IHS workforce are AI/AN
- There are many complexities of supporting 14,000 employees in over 300 locations in 37 states including diverse native cultures and traditions that create a work environment for IHS employees that is unique in DHHS
- Human resources functions and practices that work well for scientists at NIH/CDC or may work poorly for a frontline health care workforce located in rural isolated locations in Indian country.
- We are concerned that the specialized experience and support services relied on by our remotely based, frontline community based health care system would be jeopardized by consolidation into one of the 4 proposed HR locations.

We agree with the reform principle that all Federal agencies become more citizen centered and results oriented. We have practical concerns that the proposed consolidation will not achieve these goals. Consolidating at higher level in DHHS appears to move the HR function an additional step away from the frontlines of the Indian health system where the support is most needed. And, we have doubts that a composite of HR staff from differing agencies can assure the specialized knowledge and skills to support the dispersed and remote based workforce for IHS.

Recommendation: The IHS should consider consolidating and realigning "site independent" HR support functions within IHS to take advantage of new technologies and enhance HR expertise available to all IHS health care delivery sites in 37 states. To preserve the specialized experience and support for the dispersed community based health care system, IHS HR functions should <u>not</u> be consolidated with HR functions of highly dissimilar agencies. Rather, we believe that many improvements envisioned by

the Secretary can be achieved with internal restructuring carefully focused on support needs in the frontline health delivery sites.

Indian Health Facilities

The IHS is one of the few DHHS agencies with a direct health care delivery mission and consequently has unique health facility requirements. These requirements deserve a specific focus, connected to this mission and to the specific program objectives of the agency. Tribes, Congress, and the Indian Health Service have developed detailed processes for ascertaining facility needs, identifying priorities for AI/AN health facilities construction, and for determining methods for financing, design, construction and maintenance of such facilities that are tailored to the unique challenges in this operating environment. Consolidating Indian health facilities management into the DHHS health facilities management process would unnecessarily complicate these processes.

We understand that the Secretary's concerns primarily focus on federal employee office buildings and facilities. We have no objections to proposals regarding better coordination of federal office space. If the Secretary requires more information concerning IHS facilities status and issues than has traditionally been provided, there should be regular reporting at the department level.

However, with respect to hospitals and clinics located throughout Indian country, we have identified a number of concerns that trouble us. Our concerns arise from doubts that multi-agency facilities management offices will actually produce the needed results in the field especially considering the uniqueness of the IHS medical care system of over 300 sites, many in remote rural locations. Our main concerns are:

- consolidation with other agencies will unnecessarily complicate management of very diverse and dissimilar facilities systems (i.e., IHS facilities activities include

safe water and sanitation construction, hospitals, clinics, health stations, staff quarters, warehouses, etc.)

- IHS facility construction priority setting methodology, which is in response to Congressional directives, may be compromised.
- consolidation could lead to redirection of already scarce and inadequate facilities resources away from the growing backlogs of construction and maintenance needs in Indian country,
- there is strong opposition in Indian country to merging the environmental health and facilities programs into DHHS.

Recommendation: The IHS health care facilities and sanitation construction programs should remain within the Indian Health Service as currently structured. The health facilities deserve a specific focus, connected to this mission and to the specific program objectives of the IHS. We can endorse proposals for better management of federal office space that do not impact front line Indian health care facilities. Additionally, we recommend that HHS and IHS identify in Memorandum of Agreement the additional steps to assure full reporting and compliance of IHS facilities data with HHS standards.

FTE Reductions

With respect to the FTE reductions proposed in IHS FY 2003 budget justifications, our view is that the IHS has been downsizing administrative FTE and redirecting FTE to program functions for years. We understand the reference time frame for this administration begins in 2002. However, the reference time frame for the Indian health system is much longer, including several generations. We were asked to identify changes needed in the Indian health system. To do so we are obligated to assess trends and changes in our health care system over a number of years.

In looking at the longer term trends, we have observed that IHS began serious reorganization in the mid-1990s that has reduced the upper and middle administrative ranks by more than half.

{ Insert charts showing FTE reductions since 1993 HERE }

The FTE reduction in IHS management layers has been significant and has implications for the extent of additional destructing that is prudent and practical. The data suggest that IHS has achieved downsizing during the past 6-8 years to an extent rarely accomplished in other HHS agencies. We are concerned that IHS administrative functions are now about as "lean and mean" as we can reasonably expect.

As part of that redesign of IHS, Indian leaders also specified that IHS' organizational structure should be flattened and that duplicate and unnecessary offices be consolidated or eliminated. For instance, at IHS headquarters there were over 140 individually organizational elements. Today, IHS headquarters functions with 40 organizational units aligned into only 3 operational divisions.

{ Insert Before and After organizational charts for IHS headquarters. }

Downsizing and restructuring of IHS administration will continue as additional tribes take over IHS functions in self-determination contracts and grants. For Instance the Navajo Nation is in the process of contracting to operate portions of its health care system. The Navajo Nation IHS health care system accounts for more than 20% of the IHS workforce. The Navajo Nation is entitled to take more than 20% of the IHS headquarters administrative budget and more than 90% of the Navajo Area Office administrative budget as "tribal shares" as the phased transition is completed. Changes and downsizing of this magnitude are formidable even without any additional downsizing directives from HHS or the Administration. We do not believe that IHS can absorb the FTE cuts specified in the IHS budget and simultaneously downsize a FTE required to transfer of programs to

tribes over the next few years. The pace and magnitude of the combined reductions are of serious concern to us and risk possibility of severe disruptions.

Moreover, transfers of FTE and resources from the IHS appropriation to other HHS appropriations concern us greatly from the perspective of tribal rights to contract and compact for IHS resources. Such transfers will diminish the resources to which tribes are currently entitled and will diminish the resources available to them to operate the health programs. We are opposed to FTE and resource transfers that detract from tribal rights and potential operating resources.

This is one of the issues that we believe is going in the wrong direction. We are most concerned about FTE reductions, which will actually diminish resources and services to Indian people, when our larger message is that resources and health care services to Indians should be increased.

Note to RIW members:
The sections above will be further expanded, refined, and put into common format (pros/cons, etc.) Of more immediate concern is what additional items should be included in this section. For instance, the Information Technology piece may be referenced here because of HHS proposals, but may fit better into Section 3 dealing with long range plans.